IMAGING
CENTER OF COLUMBUS

CONSENT FOR TREAMENT OF A MINOR

I hereby authorize Imaging Center of Columbus, LLC to administer radiology services to my child, _____.

Dated at Imaging Center of Columbus, LLC on this _____ day of

_____, 20____.

Name of Parent or Guardian:_____

Relationship to patient:_____

Address (if different):_____

_____

Cell #_____ Work #_____

_____
(Signature of Parent or Guardian)

_____
(Printed Name of Parent or Guardian)

_____
(Witness)

REVISED 01/17/12